NEWS AND NOTES

Views

One of the puzzling aspects of the controversy about pertussis vaccination is that it did not spread to the United States. An analysis in the *New England Journal of Medicine* (1979, **301,** 906) has now concluded that in a cohort of one million children a vaccination programme would cause 3·7 cases of death or serious disability, as compared with 8·4 without vaccination—and these calculations are based on what the authors term "high estimates" of vaccine reactions.

With smallpox now extinct, vaccination of intending travellers against the disease is no longer justifiable. Yet doctors are still exposing their patients to the very real risks of the procedure (see p 1155). Some at least of Minerva's colleagues believe that any patient (other than a laboratory worker, nurse, or ambulance driver) who suffers harm from vaccination against smallpox should now sue the doctor concerned. Meanwhile, for those foreign countries which still insist on vaccination certificates, all that is needed is a signed (and authenticated) statement by a doctor that vaccination is medically inadvisable for the individual concerned.

The use of earplugs by airline pilots reduces stress, as measured by breathing rates, by a "significant" 9% (*Aviation, Space and Environmental Medicine*, 1979, **50,** 898). Which airliner will be the first to issue them to passengers?

The recently revived "Medicine and the Media" column in the "BMJ" is intending to expand a little and include longer pieces on doctors' experiences with the media: the first is printed this week (p 1137). Any doctor who has enjoyed (or suffered from) appearing on radio or television and wants to write about the experience should send his or her contribution to the editor.

Asthma and diabetes coexist in a single patient less frequently than might be expected by chance (*Journal of Allergy and Clinical Immunology*, 1979, **64,** 223). Most probably the explanation is genetic—the two diseases are associated with different HLA antigens.

Ex-foreign secretary Dr David Owen was firmly back in the health field last week at Liverpool, where he argued the case for a decentralised Health Service financed in part by local income tax. Such a system would, he claimed, lead to steadier programmes of capital investment and better control of revenue spending.

The first data submission on cimetidine to the American and Canadian drug regulation agencies comprised 47 500 pages in 160 volumes (*Pharmaceutical Journal*, 1979, **223,** 397). Such a bureaucratic paper mountain must daunt the most enterprising manufacturer. Yet are the risks of drugs proportionately reduced? Unexpected side effects still occur, as witnessed by the publications on cimetidine since its general release.

*Mortality from motor accidents has fallen in the past 10 years in most Western countries, according to the "Statistical Bulletin of the Metropolitan Life Insurance Company" (1979, **60,** 9), despite an increase in car ownership. The accepted explanations include growing use of seat-belts, lower speed limits, and better standards of driving. In parts of London the cars now move so slowly that they couldn't hurt anyone anyway.*

A strain of *Escherichia coli* has been programmed to produce human growth hormone (*Nature*, 1979, **281,** 544)—something of a breakthrough in journalistic terms, since this is by far the largest polypeptide to have been synthetised by bacteria.

How many people know that you can commit a patient with physical as opposed to mental illness to hospital under the National Assistance Act 1948? After a recent case a brief poll among local physicians produced none who had even heard of the Act.

The trichogram (a measure of various characteristics of hair) differs according to site (*British Journal of Dermatology*, 1979, **101,** 441). Pubic hair in particular changes little with aging, and unlike hair in the scalp and axilla its rate of growth does not alter during pregnancy and the puerperium.

*The cruise business is booming, but last year the "Canadian Medical Association Journal" reported that two-thirds of the ships failed to reach acceptable public health standards. This year it went back to see if there had been any improvement (1979, **121,** 998) and found that there had—but the journal advises prospective passengers to insist on agents' providing information (which they have) on a ship's state of health.*

Workers in the West Midlands have failed to confirm (*Nature*, 1979, **281,** 564) a widely quoted report from India that admissions for heart attacks were directly correlated with daily variations in geomagnetic field strength.

*Minerva has always been suspicious of chlorine in swimming pools. In a recently described episode ("Thorax," 1979, **34,** 682) children developed coughs and sore throats during a training session in a new pool, and one boy had to be admitted to hospital with asthma. The cause of what is colloquially known as "coughing water" was thought to be a new process whereby chlorine dioxide gas is pumped into the water.*

Reconstruction of the heads of three Egyptian mummies is graphically illustrated in the current *Journal of Audiovisual Media in Medicine* (1979, **2,** 156). No doubt the medical students at Manchester enjoyed dissecting the accompanying cadavers.

MINERVA

EPIDEMIOLOGY

Unnecessary smallpox vaccination

This review describes the complications of vaccination reported to the Communicable Disease Surveillance Centre in 1978 and the first three quarters of 1979. It emphasises the need to restrict vaccination firstly to the primary and secondary contacts of suspected cases of smallpox and, secondly, to certain health workers.

Since January 1978 laboratories have reported 44 patients with complications of vaccination, 25 of them in 1978 and 19 up to September 1979. The laboratory-associated outbreak of two cases of smallpox in Birmingham in August-September 1978 was notable in that no excess of vaccination reactions was reported in these months when a great many people were vaccinated. One reason for this may be that vaccination of the contacts in Birmingham was mostly carried out in controlled sessions by experienced trained personnel who were fully aware of the contraindications to the vaccine. Surveillance of contacts probably also enabled prompt diagnosis and treatment of the complications of vaccination, without the necessity for laboratory investigation. Nevertheless, many travellers were also vaccinated elsewhere in Britain at that time.

In 1978-9 cases were reported in most age groups from birth to 64 years (table). The most common reason for laboratory investigation was accidental vaccination elsewhere in the body—mostly, finger, face, or eye. The more serious complications—generalised vaccinia and eczema vaccinatum—were commoner in babies and children. In 10 of the 35 vaccination reactions for which information was available the infection was acquired either by contact with another person who had been vaccinated or by accidental inoculation.

Vaccination reactions 1978-September 1979: age and clinical features

Age (years)	Accidental vaccination*	Generalised vaccinia	Eczema vaccinatum	Encephalitis	No information	Total
<1	1	1	—	—	1	3
1-4	1	2	2	—	—	5
5-14	4	1	5	—	1	11
15-64	18	2	1	1	1	23
Not stated	2	—	—	—	—	2
	26	6	8	1	3	44

*including severe local reactions

Case reports

A child of 3 years who had infantile eczema and a congenital heart lesion developed severe eczema vaccinatum after being in contact with a recently vaccinated babysitter. Though her vaccinia lesions began to heal, she died of a staphylococcal septicaemia.

The parents of a boy of 4 years were told by the embassy (in Britain) of a N African country that vaccination was necessary before travelling there (even though the country did not appear on the WHO list of countries which still required vaccination). Vaccinia spread locally on to an area of sunburn about 12 days later and he developed group A streptococcal bacteraemia. He made a satisfactory recovery.

A woman, also travelling to a country where vaccination was not required, was vaccinated when 20 weeks pregnant. She went into spontaneous labour at 28 weeks and was delivered of a baby, covered with ulcers, who died. At necropsy, vaccinia lesions were seen in the baby's liver and lung.

An eczematous child aged 2 years developed eczema vaccinatum after playing with a neighbour's child who had recently been vaccinated for travel purposes (to a country where vaccination was not required). The initial diagnosis was chickenpox. This was later changed to possible smallpox and several persons, including children on a hospital ward, were vaccinated and surveillance of contacts was begun, before the diagnosis of vaccinia was established. The child's mother also developed vesicles. The patient's condition became critical at one time, though fortunately she recovered after treatment.

A 24-year-old woman, two months pregnant, developed a "typical" primary vaccination lesion in the antecubital fossa 12 days after a venepuncture. A vaccination clinic had been held in the same surgery the previous day. At the patient's request, the pregnancy was terminated. Virus was not isolated from the products of conception.

A man who was vaccinated against smallpox in May 1978 developed generalised vaccinia 14-21 days later. He was found to have previously undiagnosed chronic lymphatic leukaemia.

A woman of 21 years developed malaise, headache, and anorexia nine days after vaccination. On admission she was found to have blurred vision, photophobia, and definite neck stiffness; secondary vesicles were present in the anal cleft. Post-vaccinial encephalitis was diagnosed. She recovered on symptomatic treatment.

Indications for vaccination

No cases of smallpox have been reported anywhere in the world since October 1977 except the two cases in Birmingham mentioned above.[2] Routine vaccination against smallpox was discontinued in Britain in July 1971 (CMO letter 12/71) and the only medical indications for vaccination that remain apart from contacts of suspected cases of smallpox are in certain health service staff (CMO/(79)3/CNO(79)1), including those in infectious disease units and designated smallpox units, workers in laboratories in which smallpox virus is handled, and ambulance personnel designated to transport patients with smallpox.[3]

There is no medical indication for the vaccination of travellers even though the following countries still require valid vaccination certificates from all travellers on entry: Angola, Botswana, Brunei, Chad, Comoros, Congo, Democratic Kampuchea, Djibouti, East Timor, Equatorial Guinea, Guinea, Iran, Lao Peoples' Democratic Republic, Lesotho, Libyan Arab Jamahiriya, Madagascar, Mali, Mongolia, Namibia, Nepal, Oman, Philippines, Sao Tome and Principe, Seychelles, Sierra Leone, Sudan, Uganda, United Republic of Cameroon, Upper Volta, Zaire, Zimbabwe-Rhodesia. Saudi Arabia and the United Arab Emirates require vaccination certificates only until 19 November when the pilgrimage season ends.

Bolivia and Ivory Coast require travellers leaving the country to possess a certificate.

Medical practitioners should consider the issue of waiver letters to travellers to these countries stating that, as there is now no medical reason to vaccinate them, the risks of the procedure are considered to be medically unjustifiable. Such waiver letters should be authenticated in the same way as vaccination certificates.

[1] *British Medical Journal*, 1978, **2**, 837.
[2] *Weekly Epidemiological Record*, 1979, **54**, 137.
[3] *British Medical Journal*, 1979, **2**, 617.

MEDICOLEGAL

Defence Societies' Reports

FROM OUR LEGAL CORRESPONDENT

The Medical Defence Union and the Medical Protection Society have published their 1979 Annual Reports for the financial year ending 31 December 1978 and the legal year ending with the printers' deadline. So has the Medical and Dental Defence Union of Scotland but with a prudent emphasis on the fiscal side its report is dated 1978 instead. The common theme of all three reports is the financial pressure attributable to the massive recent rises in the size of awards for personal injuries.

Even the MDDUS is far from complacent, despite payments of indemnity and associated costs in 1978 of only £46 448 and swelling its indemnity reserve from £420 000 at 1 January 1978 to exactly £600 000 at the end of the year. The reinsurers required that the union should carry the first £600 000 of claims, which was contrived by transferring almost the whole of the union's income and expenditure account into the reserve. The union points out that a reserve which seems high today may be no more than adequate in 1982 or 1983, when cases intimated this year finally come to trial or reach a settlement.

Very much the same theme is echoed by the MDU and MPS and both expect annual increases in subscription rates. Like their Scottish sister, they both emphasise the cardinal importance of a strong reserve, and the MDU is now budgeting for a considerably larger surplus. As is pointed out in the MDU Report, it was the expected consequence of the old policy of fixing subscription rates for a number of years that in 1978 there was no material addition to its £4 452 902 reserves,

which were almost totally committed to expected liability for indemnity claims. The MDU's post-tax surplus was a modest £71 218, compared to £663 971 in 1977: income was almost stagnant, and expenditure rose by some £500 000, of which almost £400 000 was accounted for by increased indemnity payments (including reinsurance costs) and legal charges. The MPS is similarly placed, with stationary income and dramatically accelerating legal expenditure (costs and damages up over £0·5 million at £1 401 540) giving rise to a deficit for the year of £308 601.

One particularly well-judged commitment of legal expenditure was the MDU's successful application in the Chancery Division for a declaration that the union did not come within the ambit of the Insurance Companies Act 1974. The Department of Trade had made clear its wish to bring the defence societies within its control under the provisions of the 1974 Act, and the MDU decided to put the matter to the test. On 21 December 1978, after a three-day hearing, Sir Robert Megarry declared[1] that the MDU was not an insurance company and did not carry on any class of insurance business within the terms of the Act, and an order for costs was made against the Department. Though the MDU brought the action it was supported by its sister societies, which had the same interest in avoiding not only Government control but also the massively increased subscription rates which, according to the treasurer of the MPS, would have been necessary to comply with insurance company legislation.

Amount of damages

That was an important victory, but it has not overshadowed the real concern of the moment: the rate of increase in damages awarded by the courts. Everyone remembers the tragic case of Dr Lim Poh Choo, the psychiatric registrar who suffered brain damage after a cardiac arrest after minor gynaecological surgery. Her award of £249 239 was almost completely upheld this year by the House of Lords,[2] despite Lord Denning's warnings in the Court of Appeal that Britain was in danger of following United States trends in medical malpractice claims, and that as awards grew so did insurance premiums, which would eventually be passed on to the public in more expensive private health insurance or higher taxes. The upward trend has now been further underlined by a judgment in May in which Dr Lim's award was comprehensively overtaken. Damages of £308 000 were awarded to a 9-year-old boy who had suffered brain damage after developing meningitis, which, it was alleged, a general practitioner had failed to diagnose. But as wage levels rise and as judges, in a system which demands that damages be fixed finally once and for all, try to compensate as far as they can for future inflation awards will continue to rise steeply.

Still on the subject of damages and the reasons for their rapid inflation, the MDU Report points to the House of Lords' important decision[3] in November 1978 on what is known as the "lost years" rule. The plaintiff had developed mesothelioma of the lung as a result of inhaling asbestos dust in the course of his employment in a British Railways carriage works. At the time of trial he was 53, with a wife and two children, and—but for inhaling the dust—would have had every prospect of working to the normal retirement age of 65; but the lung disease had shortened his life expectancy to one year. Damages for loss of future earnings were limited to that one year, and the 11 "lost years" between 54 and 65 were ignored in accordance with the then established authority that damages for loss of earnings beyond the period of likely survival were irrecoverable. On appeal, the House of Lords reversed this rule, and damages will in future be awarded for economic loss resulting from diminished earning capacity for the whole of the originally expected working life.

Anaesthetic catastrophe

The largest award borne by the MPS in the past year was a particularly upsetting case of brain damage. The plaintiff, a man of 51, had been admitted to hospital after a road accident. He complained of severe abdominal pain, and the duty anaesthetist was called to assess and prepare the patient for an emergency laparatomy. For the first hour all had gone well, until surgical complications had caused the operation to be halted pending the arrival of a consultant surgeon. At this stage the patient's colour was poor and artificial ventilation seemed inadequate. Manual ventilation was tried, then more artificial ventilation, then back to manual: a second ventilator would not work manually because the reservoir bag would not fill. Cyanosis worsened, the cardiac team was called, and the consultant surgeon, who had now arrived, found no air entry to the lungs. Another endotracheal tube was passed and both ventilation and the patient's colour returned to normal. After four days of reasonable progress, there was a sudden deterioration in the level of consciousness, with no response to pain and no spontaneous movement; the pupils failed to respond to light and both legs showed some spasticity. In the light of legal opinion, liability was not contested, particularly because the reservoir bag's failure to inflate could be explained only by one of two errors: either the apparatus was not connected to the oxygen supply, or —more probably—the ventilator valves were not properly adjusted. The patient remained paralysed, mute and almost blind, and completely dependent on others for all his needs. At trial of quantum of damages alone the judge awarded him £112 187.

The need for consent to be genuinely informed was reinforced by a judgment for £3000 against a member of the MDU, who explained to his 36-year-old patient that a caesarean section would be necessary because of her large baby's breech presentation. The doctor, a locum consultant, explained that she could also be sterilised if she wished. She agreed, as did her husband, and both signed the consent form. All proceeded as planned, but over two years later she issued proceedings for assault, claiming that as a Roman Catholic she would not have consented had she not been under the influence of analgesics and sedatives. The written consent had been obtained during an emergency, and the judge said that, though the patient understood the implications of the operation, she had consented under stress and had not been advised about the irreversibility of sterilisation or given enough time to make an informed decision.

The new field of unwanted pregnancy[4] raised a claim which the MDU settled last year on behalf of a member. A nurse had a Lippe's loop removed from her abdomen through a laparoscope. A curettage was performed at the same time, and she was prescribed the contraceptive pill and seen again seven weeks later, but not examined. After several weeks abroad she complained of twenty weeks' amenorrhoea and shortly afterwards pregnancy was confirmed. In view of leading counsel's opinion that it was negligent to have missed the pregnancy by not examining the woman at her visit seven weeks after the laparoscopy the MDU settled for £2996 plus £737 costs.

One action which the MDU fought and won concerned a 39-year-old schizophrenic admitted to hospital under Section 25 of the Mental Health Act 1959. He had a history of attempted suicide, and normally such a history imposes on a hospital and its staff the duty to take precautions to prevent any further attempts. The degree of care owed will, however, always depend on the degree of risk present in each individual case.

The patient injured himself by falling from scaffolding in the hospital grounds, but expert evidence was called to support the defendant doctor's view that at the time there had been no likelihood of risk such as to justify constant surveillance of a patient for whom in any case rehabilitation, not imprisonment, was felt to be the proper aim of treatment. On that basis, and on the ground that Section 25 of the Act did not specify the mode of detention or treatment to be employed, the action was successfully defended.

[1] See also (1979) 2 WLR 686, and *British Medical Journal*, 1979, **1**, 1636.
[2] See also (1979) 3 WLR 44, and *British Medical Journal*, 1979, **2**, 397.
[3] Pickett *v* British Rail Engineering, (1979) 1 A11 ER 774.
[4] See also *British Medical Journal*, 1979, **2**, 1008.

PARLIAMENT

Transplant of Human Organs Bill

The Transplant of Human Organs Bill was given a first reading in the House of Commons on 23 October. The Bill would allow hospitals to take the organs, such as kidneys, of any patient, once clinical death has been established, other than those of a deceased person who has contracted out during his lifetime by registering, on a central computer, his desire not to donate organs.

Mr T Dalyell told the House that this was the seventh contracting-out Bill which had been introduced. The kidney donor card scheme had not worked; only a small proportion of the population carried cards. He had put forward the Bill for three reasons. Firstly, many people, with potentially useful working lives, died because of a shortage of matching tissue. Secondly, many others had to endure renal dialysis—at a cost to the NHS of £5000 per machine and £14 000 per year for running costs. Thirdly, since the deterioration of kidneys sets in 30 minutes after death and no kidney was of use one hour after death immediate decisions had to be made. Decisions about donations, he said, should not be made at the moment of maximum grief.

Questions in the Commons

Increased RHA costs. The following table gives the estimated cost to regional health authorities of increased value added tax and the Clegg awards, the increased allocations to RHAs, and the gain to the Exchequer from additional VAT.

RHA	1979-80 £m			
	Estimated cost of increased VAT	Cost of Clegg awards	Increase in allocation towards extra cost	Gain to Exchequer from additional VAT
Northern	2·4-2·7	2·6	2·3	2·4-2·7
Yorkshire	2·8-3·1	2·8	2·5	2·8-3·1
Trent	3·4-3·9	3·3	3·0	3·4-3·9
East Anglia	1·4-1·6	1·3	1·1	1·4-1·6
North-west Thames	4·0-4·5	2·6	2·3	4·0-4·5
North-east Thames	3·8-4·3	3·1	2·8	3·8-4·3
South-east Thames	3·7-4·2	3·1	2·8	3·7-4·2
South-west Thames	3·0-3·3	3·0	2·6	3·0-3·3
Wessex	2·0-2·2	1·8	1·7	2·0-2·2
Oxford	1·7-1·9	1·4	1·2	1·7-1·9
South-western	2·5-2·8	2·3	2·1	2·5-2·8
West Midlands	3·9-4·4	3·7	3·3	3·9-4·4
Mersey	2·1-2·4	2·1	1·9	2·1-2·4
North-western	3·3-3·7	3·2	2·9	3·3-3·7
Total	40·0-45·0	36·0	32·6	40·0-45·0

Social Services, 22 October.

Perinatal and infant mortality, England 1978.

	Stillbirths	Live births	Deaths under one week	Deaths under one year	Infant mortality: deaths under one year per 1000 live births	Perinatal mortality: stillbirths and deaths under one week per 1000 total births
England	4797	562 630	3974	7360	13·1	15·5
Region						
Northern	381	38 265	297	530	13·9	17·5
Yorkshire	382	43 632	336	596	13·7	16·3
Trent	446	54 377	392	718	13·2	15·3
East Anglian	169	22 073	128	238	10·8	13·4
North-west Thames	332	43 938	290	535	12·2	14·1
North-east Thames	381	46 607	326	625	13·4	15·0
South-east Thames	353	41 958	285	557	13·3	15·1
South-west Thames	235	32 588	208	420	12·9	13·5
Wessex	214	30 875	197	380	12·3	13·2
Oxford	197	29 563	203	362	12·2	13·4
South-western	319	35 531	224	441	12·4	15·1
West Midlands	641	63 814	471	871	13·6	17·3
Mersey	273	29 931	186	363	12·1	15·2
North-western	474	49 478	431	724	14·6	18·1

Social Services, 22 October.

MEDICAL NEWS

Environmental Health

On 1 November the Nuffield Provincial Hospitals Trust published a *Practical Guide for Medical Officers for Environmental Health*, compiled by Professor Andrew Semple and J K Johnston (£2·50). The guide is intended, says the trust, for community physicians, and especially those without previous public health experience, who are appointed as MOEHs. It covers topics such as notifiable diseases and food poisoning, port and airport health, and the control of pollution. While not intended as a textbook of environmental health, the 81-page booklet includes sources of further detailed information on all aspects of the work of an MOEH.

Parking for the disabled

The "orange badge" scheme for parking concessions for the disabled is to be tightened up in response to criticisms that it is being abused. Entitlement to the badge will be restricted to persons in receipt of mobility allowances; those aged 65 or over whose disability is as great as that of recipients of the mobility allowance; the blind; and persons using vehicles supplied by Government departments or receiving grants towards the use of their own vehicles.

Pet Health Council

The Association of British Pharmaceutical Industry has joined with the British Veterinary Association and the Pet Food Manufacturers' Association to establish a new association, the Pet Health Council, intended to promote the welfare of pet animals by education of their owners and of the general public.

Study group on nervous diseases

Experts from 12 countries met recently at the World Health Organisation in Geneva to study disorders of the peripheral nervous system, making recommendations on prevention, treatment, and research. Infectious diseases of nerves caused by bacteria, viruses, and environmental toxins were among the subjects discussed. The study group also discussed autoimmune disorders such as the Guillain-Barré syndrome, which is of particular concern in developing countries, as well as diabetic neuropathy and its socioeconomic implications and diseases caused by undernutrition in developing countries and malnutrition in industrialised societies.

Attacking diabetes mellitus

Diabetes mellitus is a universal health problem affecting human societies at all stages of development, with 1·0-1·5% of the world's population affected, according to the World Health Organisation's Expert Committee on Diabetes. This met in Geneva recently under the chairmanship of Professor Harry Keen. The rates are now increasing fast and will accelerate as populations age and ascertainment improves. The main health services for the diabetic should be organised at the community level, recommends the committee, preventive, curative, educational, and research activities all being based on the primary health care services. The concept of primary prevention, it says, should be vigorously explored, with particular attention paid to high-risk people and to environmental factors, including undernutrition and overnutrition.

"Crash Call"

Crash Call, a film about cardiac arrest, has been awarded a prize by the City of Strasbourg as the best educational film shown during a recent Council of Europe conference on communication techniques. Made by Southampton University's department of teaching media, the film has also been awarded a certificate by the British Life Assurance Trust and BMA Centre for Health and Education. Inquiries to Mr W J Allen, Teaching Media Department, Highfield, Southampton SO9 5NH (0703 559122 ext 785).

Information, please

Anyone who has knowledge of any non-surgical technique for removing tattoos is invited to write to Mr John M Ward, Director of Medical Records, Hotel-Dien de St Joseph, 6 Rue Arran Street, Campbellton, New Brunswick E3N 3G3, Canada.

People in the news

Dr J W Black, FRS, and Dr F Sanger, FRS, have been awarded two of the six 1979 Gairdner Foundation International Awards—Dr Black in recognition of his role in the identification of amine receptors and in the development of propranolol and cimetidine, and Dr Sanger in recognition of his development of methods for the sequencing of DNA and his contribution to new concepts of gene structure.

Correction

We much regret that in the Epidemiology article "Leptospirosis in man, British Isles, 1978" (6 October, p 872), Dr Alex Sakula's name was misspelt in the text and in the list of references.

COMING EVENTS

Royal College of Psychiatrists—Autumn quarterly meeting, 15-16 November, London. Details from the secretary to the college, 17 Belgrave Square, London SW1X 8PG. (Tel 01-235 2351-5.)

"Dietary Fibre: what is the future?"—Symposium, 27 November, London. Details from Dr I McLean Baird, Postgraduate Medical Centre, West Middlesex Hospital, Twickenham Road, Isleworth, Middx TW7 6AF. (Tel 01-560 2121.)

Institute of Urology—Uro-radiology weekend, 7-8 December, London. For details see classified advertisements.

Institute of Physics—Meeting on "Data collection in electron microscopy and analysis," 25 March 1980, London. Details from the meetings officer of the institute, 47 Belgrave Square, London SW1X 8QX.

"Drug receptors and their effectors"—Symposium, 31 March-1 April, London. Details from the administrative secretary, Mrs J Kruger, c/o Department of Pharmacology, University College London, London WC1E 6BT.

Royal College of Radiologists—Details and copies of the 1979-80 calendar are now available from the college, 38 Portland Place, London W1N 3DG. (Tel 01-636 4432-3.)

Society of Chemical Industry Microbiology, Fermentation and Enzyme Technology Group—Details and copies of the 1979-80 programmes are now available from the group, 14-15 Belgrave Square, London SW1X 8PS. (Tel 01-235 3681.)

SOCIETIES AND LECTURES

*For attending lectures marked * a fee is charged or a ticket is required. Applications should be made first to the institutions concerned.*

Monday, 5 November

INSTITUTE OF DERMATOLOGY—4.30 pm, Professor Ruth Bowden: Embryology of human skin.

ROYAL COLLEGE OF PHYSICIANS OF LONDON—5 pm, Lumleian lecture by Sir John Walton: Muscle disease—some new perspectives.

Tuesday, 6 November

INSTITUTE OF DERMATOLOGY—4.30 pm, Dr R A J Eady: The ultrastructure of the epidermis.

ROYAL COLLEGE OF PHYSICIANS OF LONDON—5 pm, Ernestine Henry lecture by Dr P C Elmes: The relative importance of cigarette smoking in occupational lung disease.

UNIVERSITY COLLEGE LONDON—1.20 pm, Professor C G Clark: A wee touch of indigestion.

Wednesday, 7 November

ASSURANCE MEDICAL SOCIETY—At Medical Society of London, 5 pm, Dr Kenneth MacLean: Personal views on the rating of certain impaired lives.

INSTITUTE OF NEUROLOGY—Sandoz Foundation advanced lectures, 6 pm, Professor L W Duchen: Experimental models of muscle disease. 7 pm, Dr E M Brett: The floppy baby.

INSTITUTE OF ORTHOPAEDICS—6 pm, Mr R Sanders: The place of microvascular surgery in trauma to the limbs. 7 pm, Mr E L Trickey: Cervical spine injury.

INSTITUTE OF PSYCHIATRY—5.30 pm, Professor Neil Kessel: Genius and madness. The enterprise of pathography.

ROYAL COLLEGE OF PHYSICIANS OF LONDON—5 pm, Tudor Edwards lecture by Professor S J G Semple: The chemical control of breathing in health and disease.

UNIVERSITY OF OXFORD—At John Radcliffe Hospital, 5 pm, Dr Howard Thomas: Hepatitis B virus infection: mechanisms and treatment.

Thursday, 8 November

QUEEN CHARLOTTE'S MATERNITY HOSPITAL—12-15 pm, Sheila Kitzinger: Support of mothers and their babies in the first week of life: mothers' experiences.

ROYAL COLLEGE OF PHYSICIANS OF LONDON—5 pm, John Thornton Ingram lecture by Dr W J Cunliffe: A clinical and computerised study of acne therapy.

ROYAL COLLEGE OF SURGEONS OF ENGLAND—5 pm, Hunterian lecture by Professor J S P Lumley: Cerebral revascularisation in stroke prophylaxis. At Royal Society of Medicine, 5 pm, Edridge-Green lecture by Dr H Ikeda: Visual acuity: its development and amblyopia.

ST MARY'S HOSPITAL MEDICAL SCHOOL—5.15 pm, Aleck Bourne lecture by Dr O A N Husain: Recent advances in gynaecological cytology

Thursday, 8 November

WEST OF SCOTLAND COMMITTEE FOR POSTGRADUATE MEDICAL EDUCATION CENTRE FOR MEDICAL WOMEN—9.30 am, Dr G Watkinson: Modern concepts in the treatment of inflammatory bowel disease.

Friday, 9 November

KENT POSTGRADUATE MEDICAL CENTRE AT CANTERBURY—8.30 pm, annual Pfizer lecture by Dr R S Williams: Recent advances in the treatment of liver disease.

UNIVERSITY OF LIVERPOOL—At Royal Liverpool Hospital, 5 pm, science, and practice of orthopaedic surgery lecture by Professor J Williamson: Bone diseases in the elderly.

Saturday, 10 November

UNIVERSITY OF LIVERPOOL—At Royal Liverpool Hospital, 9 am, science and practice of orthopaedic surgery lecture by Professor J Williamson: Orthopaedic-geriatric units.

BMA NOTICES

Central Meetings

	NOVEMBER
14 Wed	General Purposes Subcommittee (CCHMS), 2 pm.
15 Thurs	General Medical Services Committee, 10 am.
15 Thurs	Negotiating Subcommittee (CCHMS), 10 am.
15 Thurs	Consultant Radiologists Group Committee, 2 pm.
21 Wed	Mental Health Group Committee, 9.30 am.
21 Wed	Finance and General Purposes Committee, 10 am.
28 Wed	**BMA Council,** 10 am.
29 Thurs and 30 Fri	Training course for newly appointed honorary secretaries.

Division Meetings

*Members proposing to attend meetings marked * are asked to notify in advance the honorary secretary concerned.*

Coventry—At Coventry and Warwickshire Postgraduate Centre, Tuesday, 6 November, 7.30 pm, dinner/lecture, speaker Dr B McD Duxbury: "Doctors on the move."*

Dewsbury—At Staincliffe General Hospital, Wednesday, 7 November, 7.30 pm, annual clinical meeting in conjunction with the Postgraduate Centre.

Dukeries—At Mansfield General Hospital, Wednesday, 7 November, 7.15 for 8.15 pm. buffer supper followed by Professor Alan Usher: "Forensic pathology."*

Harrogate—At 63 Cornwall Road, Saturday, 10 November, 8 pm, informal supper party.*

North Warwickshire—At George Eliot Hospital, Tuesday, 6 November, 8 pm, social evening.* (Guests are invited.)

Rochdale—At Birchill Hospital, Tuesday, 6 November, 8 pm, business meeting.

Rugby—At Hospital of St Cross, Thursday, 8 November, 12.30 or 12.50 pm, working buffet lunch.*

Solihull—At Greswolde Arms Hotel, Thursday, 8 November, 7.15 pm, joint meeting with the ladies section of the Royal Medical Benevolent Fund.*

South Bedfordshire—At Durocrest Hotel, Luton, Friday, 9 November, 8 pm, annual dinner.* (Guests are invited.)

Swansea and West Glamorgan—At Top Rank Suite, Swansea, Friday, 9 November, 7.30 pm, annual ball.*

Waltham Forest—At Whipps Cross Hospital, Thursday, 7 November, 8.30 pm, Professor Desmond Pond: "Does preventive psychiatry exist?"* (Preceded by buffet supper. 7.30 pm.*)

West Derbyshire—At Barn Rest Restaurant, Bakewell, Saturday, 3 November, 7.30 for 8 pm, annual dinner, speaker Professor Eric Wilkes.*

Regional Meetings

Mersey Regional Committee for Community Medicine—At Liverpool Medical Institution, Wednesday, 7 November, 5 pm.

North-west Regional Council—At Boyd House, Manchester, Wednesday, 7 November, 4 pm.

UNIVERSITIES AND COLLEGES

MANCHESTER

MD—P E T Isaacs.

BRISTOL

MD—C M Asplin, C J Roberts.

ROYAL COLLEGE OF SURGEONS OF EDINBURGH

At a meeting of the council of the college on 15 October, the following were admitted to the Fellowship—M F Y M Abdelbaki, A M Abdelkader, H S Abou-Zeid, M A Abrahams, O P Agrawal, M R Ahmed, D J M Al-Khalifa, A M Al-Layla, S Ankaiah, A D Atkins, A R Bacha, P S Baines, N Z Bakheit, Raka Banerjee, G C Bannister, M O Bennett, B G Best, K I Bickerstaff, K A Boateng, L H Boobis, P L Brown, S S S Busaidy, S K Chaku, K-M Chan, C K Huat, K H Choong, C R Choudhury, S A Cohen, M P Collins, C M Court-Brown, G H Creasey, A C Crosby, R J Cuschieri, V Deshpande, P K Dhar, G H Dibsy, I E H El-Kharib, A M A El-Swais, F O Esechie, T S M Fahim, F Chin-Wan, D M A Francis, N T McL Galloway, S S Geeranavar, A Ghosh, B Ghosh, I G Gunn, C N Hall, N M Hamza, C Handley, N W S Harris, Patricia M A Hart, C F Harvey, G Hersman, J W Hetherington, J C Hill, R A Hodge, J H A Hussain, A R Innes, J K Jamdar, M M Janapriya, A P Johnson, A Y Jones, D J M Keenan, J-U-R Khan, A Kumar, P K Kundu, D C Y Kwan, P McL Kyle, C-M Lam, R J Lane, A I Lang-Stevenson, Anne H Lawson, L Ho-Chiu, R N Linacre, C B Lynch, T B McCartney, A Mahabir, T A A-I Majid, C V Mathewkutty, P H Mehta, I Mitra, J Mook, Elizabeth Morrison, M T Mosleh, M R Nazzal, H M Ntaba, Z A H Omran, B M Osmani, M A Owoso, N R Parikh, B R Parry, P Phongprapatana, H S Plaha, K Prabhakaran, K Pradhan, A A A Quaba, M K Raghuveersaran, C A Royes, T Russell, F A D Sabra, Pushpita Sahu, C M C Santos, L R Sawh, D J Scobie, M Shafiq, S Shantha, R N S Shawis, C L Shieff, R D Shuttleworth, B N Singh, M Singh, R P S Smith, F E Sofras, I G Syme, M A Tahir, S G Taktak, S A Tembe, J H S Thabet, R H Thomas, M P Thyagarajan, C S Ting, S S To, P C Tong, P-H Tsang, S A Vasa, I D Vyas, A P Walby, I G Williamson, K A Woods, H H Wu, A A W Yusuff.

At the annual meeting of fellows held on 17 October the following constitution of council was confirmed—Professor F John Gillingham (president); Mr R J M McCormack, Sir James Fraser (vice-presidents); Mr A C B Dean (secretary); Dr A G D Maran (treasurer); Mr J Cook, Professor H L Duthie, Mr P Edmund, Professor A P M Forrest, Mr R Myles Gibson, Mr A A Gunn, Mr D W Lamb, Professor J Lister, Mr I F MacLaren, Mr T J McNair, Mr A I S Macpherson, Mr A D Roy, Mr W A T Robb, Mr J W W Thomson, Mr W F Walker (council); Professor A W Wilkinson (council ex officio—immediate past president); Professor W D MacLennan (convener of the dental council).

Instructions to authors

The following are the minimum requirements for manuscripts submitted for publication.

A stamped addressed envelope or an international reply coupon *must* accompany the manuscript if acknowledgment of its receipt is desired.

(1) Typing should be on one side of the paper, with double or triple spacing between the lines and 5-cm margins at the top and left-hand side of the sheet.

(2) Two copies (or preferably three) should be submitted.

(3) Spelling should conform to that of *Chambers Twentieth Century Dictionary.*

(4) References must be in the Vancouver style (*BMJ*, 24 February, p 532) and their accuracy checked before submission.

(5) SI units are used for scientific measurements. In the text they should be followed by traditional units in parentheses. In tables and illustrations values are given only in SI units, but a conversion factor must be supplied. For general guidance on the International System of Units, and some useful conversion factors, see *The SI for the Health Professions* (WHO, 1977).

(6) Authors should give their names and initials, their current appointments, and not more than two degrees or diplomas. Each author must sign the covering letter as evidence of consent to publication.

(7) Letters to the Editor submitted for publication must be signed personally by all the authors.

(8) Acknowledgments will *not* be sent unless a stamped addressed envelope or an international reply coupon is enclosed.

(9) Detailed instructions are given in the *BMJ* dated 6 January 1979 (p 6).